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Hans Oberdiek
Swarthmore College, hoberdi1@swarthmore.edu

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Author(s): Hans Oberdiek
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WHO IS TO JUDGE?*

Hans Oberdiek
Swarthmore College

The title of this paper—"Who Is to Judge?"—might just as well be, "*Whose* to Judge?": that is, whose right and/or responsibility is it to judge? That this is so will, I hope, become clear in what follows.

The question, Who is to Judge? is seldom a genuine request for an answer. Rather, it is usually intended rhetorically, implying that no one can or ought to judge. Precisely what is implied, however, is often unclear. It may mask a claim that no one ever has any right to judge anything. Alternatively, it may be a claim that no one is ever in any position to judge anything. Or perhaps it claims that there are never any acceptable standards or principles one may use in judging. Finally, it may be a way of claiming that there are no acceptable procedures one may use in judging.

Considered as unrestricted claims, each of these is clearly and obviously false. Individuals often have a legal right—sometimes, indeed, a legal duty—to judge. In legal disputes between states, for instance, federal courts have the legal right and duty to settle the dispute. Moreover, people are often in a good—sometimes ideal—position to judge. They may occupy this position through training, as in the case of those who grade apples and oranges; through designated position, as in the case of umpires; through experience, as in the case of connoisseurs of wine; or through sheer (bad) luck, as in the case of a witness to an accident. Naturally, these positions are not exclusive: a surgeon may be in a good position to know what needs to be removed from a patient because of his training, designated position at the operating table, and experience. Analogous considerations would demonstrate the falsity of the other two possible contentions.

Those who rhetorically ask, Who is to Judge? will protest that they never intended their claims to have an unrestricted range. Rather, they will continue, they mean them to extend only to moral and nonconventional value judgments. And that is fair enough, though it would be worthwhile to ask why ethics should

*An earlier version of this paper was read at the University of Florida in April 1975. I am grateful to the Ring Committee on Social Ethics for giving me the opportunity to deliver this paper and to those in the audience who provided instructive and helpful criticisms.

be singled out for special treatment. I suspect we would find an implicit, if not explicit, appeal to certain *au courant* notions; namely, that the gulf separating facts from values, 'is' from 'ought,' prevents moral utterances from being anything more than expressions of emotion or expressions of personal (or social) commitment.

Ignoring these suspicions, let us look instead at the alternative claims masked by the question, Who is to Judge?: First, no one ever has any moral right to judge the rightness or wrongness, goodness or badness, of any act, policy, state of affairs, or institution; second, no one is ever in any position to make a reasoned moral judgment; third, there are no reasonable, justifiable moral standards, principles, rules, or criteria one may use in making moral judgments; and, fourth, there are no reasonable, justifiable procedures for settling moral disputes or for solving moral problems.

Each of these claims has distinct assumptions and implications, and therefore distinct arguments can be urged for and against each. The third, for instance, entails that no moral assertion is well grounded, though this is not entailed by either the first or second contention. Or, to consider another example, one might argue that there are sound moral principles but that the complexity of human affairs is such that no one can apply them with any assurance, hence no one has any moral right to judge. The point is simply that each claim, its assumptions, implications, and supporting arguments, must be distinguished if progress is to be made in determining the scope and soundness of the contentions embodied in the rhetorical question before us. The meaning and scope of the first two claims, for example, require further clarification. I shall construe both as silent regarding one's moral right to make judgments on moral matters; that is, neither states nor implies that one may or may not say, believe, or think that X is right or wrong, good or bad. Rather, I shall construe both as holding that no one has a moral right to determine the outcome of any moral matter; that is, both imply that no one has a moral right to permit, require, or prevent any action or policy on purely moral grounds. Thus, it might be contended that a teacher has the right to require a student to read a certain book, provided that the grounds are educational, but that no one has any right to require anyone to read anything if one's grounds are merely moral.

Each claim before us must be met, and met squarely. However, they cannot be met at once, all at once, or once and for all, since, as we have seen already, each involves varied, complex, and far-reaching issues. I shall confine myself to a consideration of how these claims might be countered in a specific instance.

We humans wear out, and when we do, we die. Sometimes, however, only a part of us wears out or is damaged, the rest of us remaining in passable condition. Yet if a vital organ is involved, death is almost certain to follow, unless we can be provided with one or more spare parts. Here there is some good news and some bad news. The good news is that spare parts, both artificial and natural, are available for use; the bad news is that there are not now and perhaps never will be enough spare parts—or adequate funding—to go around. Consequently, many people die each year who would live if only there were enough artificial kidney machines, kidneys, hearts, lungs, and other lifesaving devices and organs. Thus the

problem must be faced of determining who is to live and who is to die. It is to this problem, the problem of allocation, that one is likely to hear the rhetorical response, But who is to judge?

One answer to this latter question is good as far as it goes, and, philosophically, it goes pretty far. The question is not so much *who* shall judge, but *how* should anyone judge? That is, what principles and criteria are morally relevant in determining who should receive scarce lifesaving organs and devices? Once we determine how any of us is to judge, that is, once we determine correct or justifiable standards of judgment, then the question of who is to judge will fade in importance, for presumably a substantial number of people will be able to apply such standards with roughly uniform results.

As I say, philosophically this answer goes pretty far. Mathematicians and scientists are seldom asked, Who is to judge what the implications of Godel's theorem are? or Who is to judge whether aerosol sprays disturb the ozone layer? The proper response is that any competent and informed mathematician or scientist can judge provided, of course, that he or she knows the correct standards to employ; if there are no correct standards, or if there is great controversy regarding them, then at best one can only make an informed guess. Mathematicians and scientists therefore strive to formulate or discover correct standards of judgment.

A modified form of this direct approach is not out of place in ethics. Indeed, it is evidenced in recent published contributions to discussions regarding abortion, civil disobedience, affirmative action, the allocation of scarce resources, and other contemporary social issues. That is, an attempt is made to establish a sound, justifiable set of criteria for determining if and under what conditions certain kinds of acts or policies may be vindicated. After decades during which philosophers confined themselves almost exclusively to metaethical issues, this development is as welcome as it is refreshing.

But social practices and institutions change more slowly than individual beliefs, a fact which is well known and, on the whole, desirable. As a consequence, however, exclusive reliance on the direct approach may have little effect, for those with effective control of practices and institutions may not hear, take notice, or accept the conclusions of those social critics out of power. I shall therefore adopt a less direct route in supplementing—but not replacing—the more direct route in the hope that the two together will be more effective in bringing about desirable social change. At the same time, I hope to go some distance in countering the four claims discussed and listed above.

If, for the time being only, we set aside questions of how we are to decide who shall receive scarce lifesaving devices and organs, do we have an answer to those who ask, Who is to judge? Although physicians are not the sole judges of who gets what in these matters at present, certainly their judgment carries the greatest weight; for the most part, indeed, in *making* a judgment a physician (or a group of physicians) will be *passing* judgment. We must not deceive ourselves: moral judgments determining who shall live and who shall die are, will be, and must be made. There is no alternative.

Some may deny that physicians are either making or passing moral judgments; rather, it may be argued, all judgments are, can, and should be purely

medical and scientific, not moral. Now it is incontrovertible that judgments, and therefore decisions, regarding the allocation of scarce lifesaving devices and organs involve purely medical matters. But if one concludes from this that such judgments belong solely to physicians, then one may just as well argue that the question of capital punishment would be best left to electrical and chemical engineers!

To maintain the myth that questions regarding the allocation of scarce resources, whether in medicine, economics, or elsewhere, are purely or even primarily technical and scientific is comforting, because we can avoid responsibility for their answers, since few of us are technicians or scientists. But to hide from our responsibility in this way is not only "bad faith"; it is also bad judgment and worse policy, as it effectivly prevents us from examining our policies and practices from an examined moral point of view. If we persist in masking the moral dimensions of problems of allocation, we can hardly hope to arrive at their satisfactory solution, for no problem can be solved if it is persistently misdescribed.

After conceding this much, it may still be contended that, since allocation problems are problems for physicians, physicians alone should solve them. Again, it is incontrovertible that allocative problems are problems for physicians, and they no doubt feel them more keenly and acutely than most of us. They are not, however, merely problems for physicians; they are equally, if not more so, problems for those affected, their families, and—though to a lesser extent—everyone else. They are, in short, social problems. Notice, moreover, that anyone advocating this line of defense is smuggling in his own moral predilections, for implicit in this defense is the claim that only those for whom X is an acutely felt moral problem have a moral right or are in a position to resolve it. Even if this were so, which arguably it is not, it would seem to imply that prospective users of scarce medical resources should have a loud voice in determining criteria of allocation, as they, above all, are acutely affected by any criteria that determine who shall get how much of what. One reason questions of allocation seem to be peculiarly problems for physicians is simply that physicians now possess virtually unchallenged power to answer them.

Here it may be appropriate to say that nothing in this paper should be construed as a harangue against physicians. For the most part they have acted more decently than the rest of us, since they recognized from the beginning that hard moral decisions cannot be avoided, and they have not shrunk from the inordinate burden of responsibility our unwillingness has thrust upon them. Because the burden is inordinate, however, what was not particularly sought by physicians in the first place must be shared by more of us. No matter how much we reclaim abdicated responsibility, physicians will continue to carry heavy responsibilities.

There may be those who still cling to the belief that physicians alone should decide questions of allocation on the ground that, in these matters, physicians alone are authorities. But this is simply a confusion. Granted that a board-certified physician is an authority in his particular specialty, it is a non sequitur to conclude that he is an authority on any moral aspects of allocative questions. Indeed, it is doubtful that anyone could be an authority in the requisite sense. The difficulty is not that there are no correct or acceptable criteria; in large part the difficulty has

to do with what it is to be an authority. One authority on the concept of authority writes: "A person is *an* authority in virtue of possessing extensive knowledge of a field or subject-matter. There seem to be no limits on what the field or subject-matter can be. . . . But the knowledge . . . must form a connected whole . . . which has sufficient unity that it can be given a name."[1]

While there can be and in fact are authorities on ethical theory, and on the issues involved in a given moral problem, it does not follow that anyone is an authority on, say, the morality of abortion, the limits of justified civil disobedience, or the proper distribution of health services. Of course, one can and should become informed regarding the multiplicity of issues comprising moral problems, yet even complete information, whatever that might mean, would not be sufficient to transform one into a moral expert or authority. What more is required will not be discussed here. Even if there are no moral authorities in the requisite sense, however, it does not follow that moral judgments are necessarily vacuous or unfounded or untrue. Only when there exists a broad, unified, and widely shared network of moral beliefs and ethical theory does the notion of a moral authority make much sense. Perhaps such networks have existed in times past; certainly none exist now. Moral and evaluative judgments can nonetheless be meaningful, well grounded, and true for all of that: we simply will not have the luxury of any shortcut appeal to authority. In holding that there are no (present) moral authorities, one need not deny that the judgment of certain individuals deserves great weight. Some people, because of their experience, training, integrity, and other virtues of character, intellect, and insight, appear to have an extraordinary grasp of moral issues—even when the reasons adduced for their judgments do not seem especially persuasive. Why this appears to be so must be left for another occasion.

Yet even if one could become a moral authority in the requisite sense, there is little reason to believe that physicians would be in a particularly good position to become moral authorities. The years of training and experience required to become a skilled clinician often rob physicians of time to think through complicated moral issues; they are rightly preoccupied with thinking through complicated medical issues.

Why, then, are physicians often accepted as moral authorities regarding the allocation of scarce lifesaving devices and organs? At least part of the answer lies in the fact that a physician is normally *in* authority as well as being *an* authority: "A person is *in* authority by virtue of occupying a position or office in a social institution with an hierarchial structure."[2] Now we need not quarrel with the fact that physicians are in authority, that is, that they hold positions of authority regarding purely medical matters. Ideally, a physician is in authority because he or she is an authority on medical matters. If one acknowledges that no physician—just as no philospher—is a moral authority, then one must question why any physician should be in authority over allocative questions which are primarily and essentially moral.

1. Gary Young, "Authority," *Canadian Journal of Philosophy* 3 (June 1974): 563.
2. Ibid., p. 564.

I shall mention, though only in passing, a further explanation for the fact that physicians are frequently accepted as moral authorities. It can be traced in part to what Max Weber calls *charismatic* authority: authority resting on "devotion to the specific and exceptional sanctity, heroism or exemplary character of an individual person, and of the normative patterns or order revealed or ordained by him".[3] To this may be added the propensity of man to respect the moral and political judgments of those who possess arcane knowledge or wield great power. So physicians, regardless of their own preferences, are often miscast in the leading role of moral authorities.

One might accept all or most of what has been said thus far, yet persist in maintaining that no one has a right to make moral judgments or that no one is in a position to pass moral judgment, especially if there are no moral authorities. Yet it is not clear how this could be made out. It might be argued that if physicians have no moral right to judge, then, since physicians are not alone in not being moral authorities, no one has any right to judge. But this is morally absurd. If no one has a moral right to judge, then no one ought to judge; consequently, available but scarce spare parts ought not be distributed at all. And this is as unjustified as it is silly, for the absence of moral authorities does not entail the absence of moral rights. In the kind of case before us it is imperative that we establish a system of such rights just because the consequences of denying any individual or group the moral right to judge would be disastrous. The question then becomes, Who shall be granted the moral and legal right to judge, and on what grounds? Or, as was stated at the outset, Whose is it to judge?

Clearly, everyone's interests are involved to some extent, and potentially everyone's interests are involved to a large extent, for anyone may need a spare part or two before wearing out altogether. Now if the concept of a moral right has any validity, then everyone (or nearly everyone) is eligible to judge, in the sense of possessing a moral right to pass judgment, that is, to affect individual conduct, social practices, and institutions. For suppose that no one possessed a moral right to pass judgment. On this supposition the very concept of a moral right would lose signification: nothing can be a right which does not entitle someone to affect conduct, practices, or institutions. Indeed, the only reason to maintain that everyone has a right to hold moral views is that we wish to protect one's ability to affect the thought and action of oneself and others. After all, we need not invoke the majestic concept of the right to protect one's ability to hold moral views *simpliciter*: everyone holds moral beliefs regardless of any right to do so.

An ethical system may of course be devised which dispenses with the concept of a right altogether, and it is sometimes maintained that the ancient Greeks did just that. Perhaps, though it is risky to infer from the fact that ancient Greek has no term which readily translates as 'rights' that the Greeks had no concept of rights. Certainly they believed that there were what may be called 'entitlements' to action, political office, and property with clearly demarcated limits: citizens, met-

3. Max Weber, *The Theory of Social and Economic Organization*, trans. A. M. Henderson and Talcott Parsons (New York: Oxford University Press, 1947), pp. 324 ff.

ics, women, and slaves possessed distinct sets of entitlements, for example. And, as Socrates never questioned, Athenian juries were certainly entitled to pass judgment on a variety of matters which came before them. It is true that Athenians do not appear to have had a place in their system for individual rights, but that does not show that they lacked a concept of individual rights, let alone any concept of rights whatever. Whether or not Athenians or other ancient Greeks had a concept of rights similar to ours, it does appear that their conceptual system was rich enough to fulfill the central functions rights serve. In particular, every society must have some way of determining who is eligible to judge fundamental issues and on what grounds. While this is normally accomplished through legal systems in complex societies, only if these legal systems are morally grounded do they deserve our respect, support, and compliance. And our system of legal rights is grounded, in part, by appeal to moral rights.

Obviously, from the premise that nearly everyone is eligible to have a right to judge it does not follow that everyone actually possesses that right, for then nothing would ever be decided and that would be self-defeating. A somewhat analogous situation obtains in law. Nearly everyone is eligible to have the right to sit on a jury, though only a handful of people actually possess that right in any given case. But can there be anything like a jury to pass on moral issues raised in connection with the allocation of scarce lifesaving devices and organs, and, if so, how might it work? These questions must be faced, for perhaps the main reason physicians alone now have the right and duty to judge is simple and persuasive: no one has come up with a better alternative.

Here is one alternative. In each state a special Lay Allocation Board would be charged with developing a set of normative (as opposed to medical) criteria physicians must use in selecting those who may receive scarce lifesaving devices and organs. Medical considerations could not be completely excluded from consideration, of course, as degree of medical risk might well be thought appropriate to take into account when spare parts are especially scarce. The envisaged allocation board would have an advisory staff much as a congressional committee does. Solicited and unsolicited position papers would be considered from interested individuals and groups, and open hearings might be held from time to time. The board itself might wish to publish its own tentative position papers as its deliberations progressed. In due course, after the committee's final recommendations had been promulgated and time provided for challenges to them, the board's criteria of allocation would become binding.

Much more obviously needs to be said. Precisely which procedures are adopted by the board is extremely important, for instance, because procedures influence outcome. Although little more will be said, a brief discussion of the board's composition may be helpful. Clearly, every member ought to be disinterested; that is, like an ideal judge or umpire, no board member should have a vested interest in the outcome of the board's deliberations or decisions. Moreover, each member would have to possess the intelligence and capacity to understand the medical, moral, and social ramifications of alternative sets of criteria. Beyond these, there are other characteristics one would naturally look for: the ability to think clearly, to articulate one's reasons for and against alternative proposals, to stick by one's

convictions without being bullheaded, and so on. In general, one would look for the sort of intelligence, integrity, and judgment required of anyone in a position of great responsibility.

Board members would also have to have the capacity, ability, and willingness to put themselves in a position where they can become competent to judge. Plausibility is lent to the claim that no one is ever in any position to make reasoned moral judgments because too often we are satisfied to make casual, uninformed, and therefore irresponsible judgments. As becoming competent entails becoming informed, board members would be required to review and discuss case studies, interview physicians, and acquaint themselves with popular, religious, and philosophic literature on the subject.

Finally, board members should represent more than one sex, race, religious denomination, and socioeconomic class, for assumptions one brings to moral deliberations are often unconsciously biased. A case in point may be found in the *British Medical Journal* of March 11, 1967, where Dr. M. A. Wilson asserts that in selecting patients for haemodialysis, "gainful employment in a well chosen occupation is necessary to achieve the best results" since "only the minority wish to live on charity."[4] It is arguable, I suppose, that the gainfully employed offer the best medical risks, but it is evident that Wilson has something quite different in mind. One can only attribute such errant nonsense to class bias or some similar prejudice. Now one can imagine, though only barely, some board of allocation incorporating Wilson's pronouncement into their own set of allocative criteria, but at least it would be out in the open and subject to challenge, legal and otherwise. As things now stand, decisions may be made on the basis of widely divergent subjective views of physicians with only a slight chance that their views may be challenged or even known, save for an occasional colleague.

In requiring that board members represent diverse backgrounds, it should not be thought that they are to represent their backgrounds. One can be representative of a group without being its representative. The reason for requiring broad representation is not that members should serve as appointed representatives of their natural constituencies. Far from it. Board members must think for themselves, and not think of themselves as representing any special interest group. The primary reason for requiring broad representation is that one's perspective is often influenced, for good or ill, by one's background.

In addition to the board of allocation, hospitals which authorize spare-part surgery and treatment must have a review panel with the power and responsibility to see that the criteria are understood, instituted, and followed. At least one-third of such panels should be laymen and at least one member should be an attorney experienced in the area of medical law. The remaining members could be staff physicians. These panels could also recommend changes to its parent board of allocation.

Needless to say, the foregoing is merely a sketch. And no doubt the criteria

4. J. D. N. Nabarro, F. M. Parsons, R. Shakman, and M. A. Wilson, "Selection of Patients for Haemodialysis," *British Medical Journal* (March 11, 1967), p. 623; quoted in Rescher (n. 5 below).

of allocation eventually decided upon would be imperfect. But imperfection itself implies objectivity, for where there is no objectivity there is neither perfection nor imperfection. Any set of criteria will have its critics: criticism may come from those who believe that their interests and concerns have been slighted or ignored altogether; from those who express minority moral points of view; or from those who believe that the proposed criteria are vague, ambiguous, needlessly cumbersome, or otherwise unworkable. Such criticism must be met forthrightly, and that should not be an impossibility: to meet criticism does not mean to satisfy one's critics—it means to give a reasoned justification for one's policies.

In defense of my proposal, I shall consider a few prima facie objections which might be lodged against it; there are undoubtedly more.

1. "Choosing board members will become a political football because the AMA and other pressure groups will have a vested and intense interest in how the members will be chosen and who will choose them." The composition of allocation boards could become a political football, though it is unlikely, in that any game played with this particular football would almost certainly end in a loss for all sides! Still, it is a genuine danger which must be guarded against. Perhaps one safeguard would be to have the governor, along with legislative leaders from each major party, select among candidates recommended by responsible religious, educational, and social organizations, such as labor unions. A further safeguard would be to appoint board members for three- to five-year nonrenewable terms. While such boards would have some of the functions of our regulatory agencies, they would have quite different concerns and fewer temptations. They would be less likely to be faced, for example, with constantly shifting economic conditions, nor would they be faced with known sums of money or known beneficiaries of their decisions; and finally, it is unlikely that they would be faced with conflicts of interest. One last point. We need not fear any great bureaucracy emerging from my proposal: we need only the board, its research and secretarial staff, and the various review panels.

2. "By laying down binding criteria, allocation boards will, in effect, pass down death sentences on individuals who are not permitted their day in court. Further, physicians will find themselves straitjacketed by an anonymous board." There is more emotion in this objection than reason. First, any selection procedure—whether conducted by a physician or a board—involves, or may involve, denying lifesaving help to some. The only difference is that this fact is now pretty well hidden from public view. By making allocative criteria public, everyone will have a clearer idea of where they stand.

There is no reason, second, why someone who felt wronged could not appeal, at least to the review panel. Even now a disgruntled patient (or his heirs!) can bring suit if he believes that he has been denied what is legally his. Under present conditions, however, one who is rejected as a recipient of a lifesaving device or organ has little if any opportunity to appeal his physician's decision and so is also denied his day in court.

Finally, there is no reason to believe that physicians will be straitjacketed, for there is no reason to believe that all manner of discretion will be taken from them. We should not assume that allocative boards would even be tempted to adopt

complex and highly restrictive criteria. John Stuart Mill once remarked that any moral principle would work badly if we supposed universal idiocy to be conjoined to it! The same is true of proposals for social reform. Surely boards of allocation would seek to establish relatively simple, plausible, and enforceable criteria that are likely to win high acceptance and therefore compliance among physicians and the public generally.

3. "No matter how just their criteria, the proposed boards of allocation would serve only to hide the main problem: namely, the refusal of our state and national governments to spend what it should on medical care. To set up criteria of allocation makes it look as if lifesaving devices and even organs are necessarily in scarce supply, when in fact there could be more than enough to go around if only the government stepped in with adequate funding for research, development, and treatment." There is a great deal of merit in this objection. Nevertheless, there is nothing incompatible with establishing allocative criteria and working for fundamental social change. Moreover, the publicity allocation boards would engender is one way of bringing our inadequate funding of medical care to the attention of the public and its legislators. Further, if a modified lottery were adopted as a method of selection, even the wealthy would have an interest in seeing to it that fundamental changes in the financing of medical care were undertaken. Recall that once a lottery replaced college deferments in our draft system, both college students and their parents took a far greater interest in the Vietnam War. Last, while kidney machines may someday become as plentiful and inexpensive as power lawn mowers, it is unlikely that hearts, lungs, kidneys, or eyes will become plentiful. It is therefore unrealistic to suppose that we shall ever be so fortunate that allocative problems disappear.

I believe that a set of principles can be formulated and defended that meet reasonable standards of acceptability, and that these principles will emerge as the envisaged boards of allocation progress in their deliberations. As Nicholas Rescher points out, any reasonable selection procedure "must be *simple* enough to be readily intelligible, and it must be *plausible*, that is, patently reasonable in a way that can be apprehended easily and without involving ramified subtleties."[5] Without going into great detail, it might be useful to discuss Rescher's own suggestions, especially since they appear to violate his own regulative requirements.

According to Rescher, two distinguishable types of criteria are needed: criteria of inclusion and criteria of comparison. "We can think of the selection as being made by a two stage process: (1) the selection from among all possible candidates (by a suitable screening process) of a group to be taken under serious consideration as candidates for therapy, and then (2) the actual singling out, within this group, of the particular individuals to whom therapy is to be given. Thus the first process narrows down the range of comparative choice by eliminating *en bloc* whole categories of potential candidates. The second process calls for a more refined, case-by-case comparison of those candidates that remain."[6] This is exactly

5. Nicholas Rescher, "The Allocation of Exotic Medical Lifesaving Therapy," *Ethics* 79 (April 1969): 175; reprinted in *Ethics and Public Policy*, edited by Tom L. Beauchamp (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1975), pp. 425–41.

6. Ibid., p. 175.

one stage too many: the second stage calls for implausibly refined judgments. Reasonable grounds can be provided for excluding those who are critically ill with other diseases, psychologically unable (or unwilling) to cope with the tremendous stress involved in organ transplants and continuing renal dialysis, or very elderly. Similarly, reasonable grounds can be provided for including those whose prospects are particularly good, children and parents of children under twenty-one, and those who need only the temporary use of kidney machines. No doubt there are a few other reasonable criteria of inclusion. But to suggest that case-by-case comparisons be made within a pool of selected candidates supposes principles, standards, and criteria that simply cannot be established.

Two of Rescher's proposed criteria of comparison are clearly untenable: neither can be adequately formulated nor justly applied. In the course of defending what he calls "the potential future-contributions factor," Rescher argues:

> In "choosing to save" one life rather than another, "the society," through the mediation of the particular medical institution in question . . . is clearly warranted in considering the likely pattern of future *services to be rendered* by the patient (adequate recovery assumed), considering his age, talent, training, and past record of performance. In its allocations of ELT [Exotic Lifesaving Therapy], society "invests" a scarce resource in one person as against another and is thus entitled to look to the probable prospective "return" on its investment. . . . The fact that the standard is difficult to apply is certainly no reason for not attempting to apply it. The problem of ELT selection is inevitably burdened with difficult standards.[7]

As "a morally necessary correlative" of the above prospective service criterion, Rescher would add a retrospective service criterion, mainly on grounds of equity (though he believes that a utilitarian defense could also be attempted).[8]

Now in deciding to support the research, capital investment, salaries, and treatment costs involved in ELT, we must indeed ask whether our investment of time, talent, and money might not be better spent. Arguably, we ought to spend more on prevention of various pedestrian causes of death and ill health than on exotic lifesaving therapies. Even assuming that conventional methods of prevention and treatment need not suffer because of expensive exotic therapies, the demand for replacement of vital organs will continue to outstrip the supply for the indefinite future, thus leaving us with acute problems of allocation. Yet this fact should not lead us to embrace either of Rescher's criteria. We need only adopt criteria for candidate inclusion, for example, prospect of success, life expectancy, and family responsibilities. Should these criteria not sufficiently drain the candidate pool, then a lottery could be employed. In using a lottery, we would at once recognize the limits of human judgment and objectivity, lessen the likelihood of arbitrary and invidious distinctions, and diminish the amount of special pleading.

There is little need to belabor the virtues of a lottery over Rescher's proposed criteria. As our most recent experience with the draft demonstrated, everyone has grounds for claiming exemption—everyone, that is, except he who is poor, illiterate, or otherwise disadvantaged. This is not to say that everyone is equally deserving of having his life saved. It is only to say that any institutional (or individual) attempt to determine whose services to society, prospective or retrospective, are

7. Ibid., p. 178.
8. Ibid., p. 179.

more deserving imposes an impossible burden. (Nor need we fear that a lottery within the candidate pool would exclude a president, admiral, senator, or director of the Manhattan Project; whether justifiable or not, every system manages to find a way of providing for such cases.)

The foregoing is not intended as a definitive statement regarding acceptable and unacceptable criteria; it is merely a preliminary and cursory discussion of a few obvious issues and classifications boards of allocation would surely consider. The boards themselves would have the task of determining selection criteria, enforcement, and appeal procedures. But perhaps enough has been said to show that reasonable criteria and procedures can be formulated and defended which would also meet with public acceptance. Even if the outcomes of the various boards' deliberations are not always what we believe they should be, we shall at least have the satisfaction of knowing where we stand. And this in itself would be a significant step forward. For in moral matters, the beginning of wisdom (as Kant saw clearly) lies in recognizing that in the end the question, Who is to Judge? admits of but one answer: each and every one of us must judge. The end of wisdom, of course, lies in establishing and applying moral principles that will aid us in determining how we are to judge.